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FM AMEMBASSY NEW DELHI
TO RUEHC/SECSTATE WASHDC IMMEDIATE 3657
INFO RUEHZN/ENVIRONMENT SCIENCE AND TECHNOLOGY COLLECTIVE
RUEHBJ/AMEMBASSY BEIJING 5548
RUEHLM/AMEMBASSY COLOMBO 9057
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RUEHIL/AMEMBASSY ISLAMABAD 2352
RUEHKT/AMEMBASSY KATHMANDU 9769
RUEHMO/AMEMBASSY MOSCOW 1571
RUEHUL/AMEMBASSY SEOUL 1143
RUEHKO/AMEMBASSY TOKYO 4567
RUEHCN/AMCONSUL CHENGDU 0162
RUEHCG/AMCONSUL CHENNAI 9260
RUEHGZ/AMCONSUL GUANGZHOU 0363
RUEHHK/AMCONSUL HONG KONG 4565
RUEHKP/AMCONSUL KARACHI 7011
RUEHLH/AMCONSUL LAHORE 3686
RUEHBI/AMCONSUL MUMBAI 8432
RUEHPW/AMCONSUL PESHAWAR 4264
RUEHGH/AMCONSUL SHANGHAI 0087
RUEHSH/AMCONSUL SHENYANG 0187
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UNCLAS SECTION 01 OF 05 NEW DELHI 001098

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DEPT FOR SCA/INS, HHS FOR OGHA STEIGER/BHAT, CDC FOR
BLOUNT/COX, NIH FOR GLASS/HILEMAN, OES/PCI FOR STEWART,
OES/IHA FOR SINGER, GENEVA FOR WHO, APHIS/KOREA FOR ANDY
BALL

E.O. 12958: N/A

TAGS: [PGOV](#) [AMED](#) [EAGR](#) [IN](#) [KFLU](#) [ECON](#) [PREL](#) [SENV](#) [TBIO](#) [PTER](#)
SUBJECT: CHIKUNGUNYA VIRUS RE-EMERGES IN INDIA - MAN VS.
MOSQUITO FIGHT CONTINUES

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¶1. (U) Summary: After a 32 year hiatus, the chikungunya virus is making a comeback in India. While the Government of India (GOI) estimates over 180,000 cases of chikungunya infection since December 2005, the actual number of cases is difficult to assess. The GOI's lack of transparency in reporting, problems with effective diagnosis, and the states' seeming inability to track the virus make chikungunya a very serious public health problem. This time the virus has spread widely, with infections cropping up in rural and urban areas, as well as areas that attract mass tourism. Previous outbreaks were limited. One of our Mission officers contracted chikungunya, putting a personal face on this horrid disease. This cable looks at the state of the public health system for diagnosis and reporting, and speculates on

chikungunya as a possible bioterrorism agent. End Summary

WHAT IS CHIKUNGUNYA?

¶2. (U) The chikungunya virus was first recognized in epidemic form in Tanzania, East Africa in 1952. This virus is spread from the bite of an infected mosquito. In Asia, (including India) the main vector is the mosquito species, Aedes Aegypti. In other parts of the world, chikungunya is transmitted through the Aedes Albopictus species. Kolkata reported India's first chikungunya virus outbreak in 1963. At that time, scientists identified the virus as being of Asian origin. For the current outbreak, scientists from the Indian Council of Medical Research, (ICMR) premier virology laboratory, the National Institute of Virology (NIV) in Pune determined the virus is of African origin.

¶3. (U) The disease, first described after the outbreak on the Makonde Plateau, along the border between Tanganyika and Mozambique, is derived from a Makonde word meaning &that which bends up.8 Victims of the viral disease abruptly manifest symptoms--acute onset of moderate-to-high fever accompanied with body ache, backache, and joint pain affecting primarily the knees, ankles, wrists, hands and feet. Joint pain is severe and incapacitating, causing the infected individual to &bend8 or hunch over from the pain, hence its name. According to the Centers for Disease Control (CDC), the incubation period (time from infection to illness) is anywhere from 3-7 days.

¶4. (U) Symptoms and incubation period were directly experienced by New Delhi Poloff, bitten by a mosquito

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infected with the virus, after arriving in Chennai on November 28, 2006. A mosquito infected with the virus bit Poloff Saturday, December 2, 2006 and she began manifesting symptoms 3-4 days later on Tuesday, December 5. Symptoms included excruciating and incapacitating muscle and joint pain, high fever (reaching 105 degrees Fahrenheit), nausea, headache, vomiting, swelling of the muscles and joints, general fatigue, and a full body rash. The joint pain and fatigue has been prolonged, lasting several months. The joint pain subsided only after 3-4 months.

MISSION IMPACT

¶5. (U) New Delhi PolOff is among one of three confirmed chikungunya infections among the staff of Mission India. Embassy New Delhi has documented three confirmed cases among EFMs and Mission personnel; Consulate Chennai has also documented 4 suspected cases among FSNs; there are no reported cases among Mission Personnel in Kolkata or Mumbai.

DIAGNOSIS, TREATMENT, AND PREVENTION

¶6. (U) There are critical problems with diagnosis due to poor infrastructure at labs in India and chikungunya,s similarities with dengue. Typically, diagnosis is based on a process of elimination. Once typhoid, malaria, and dengue are ruled out, the assumption is then that the symptoms are a result of chikungunya. In India both the National Institute for Communicable Diseases in Delhi (NICD) and the NIV at Pune provide testing facilities which take 3-4 weeks for a result.

This process is long, frustrating, not widely accessible, and often inaccurate. In the case of our PolOff, it took 5 weeks to return a negative result for chikungunya from NICD. New Delhi Health Unit resent PolOff,s blood sample to the Armed Forces Research Institute of Medical Services (AFRIMS) lab in Thailand, which returns the most reliable results. Two months after being infected, PolOff finally got a positive diagnosis of the virus. Consulate Chennai also reports no accurate, quality testing lab there for chikungunya.

Additionally, the virus is often misdiagnosed as dengue due to the similar co-circulation, antibodies, and manifestation of symptoms. On the positive side, infection of chikungunya is thought to confer lifelong immunity to the individual infected.

¶7. (U) CDC,s Outbreak Notice and information to travelers is

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available at webaddress:

http://www.cdc.gov/travel/other/2006/chikungunya_india.htm. Present treatment includes rest, fluids, and drugs such as ibuprofen, naproxen, acetaminophen, or paracetamol to relieve symptoms of fever and joint pain. Infected Poloff took approximately 1200 mg of ibuprofen (anti-inflammatory) and 2000-3000 mg of acetaminophen and Tramadol daily, which only helped to take the edge off the pain. The best way to avoid infection is to prevent mosquito bites, including wearing long sleeves and pants and wearing mosquito repellent. Additionally, a person with chikungunya should limit exposure to mosquito bites to avoid further spread of the mosquito borne infection.

WHERE DID INDIA,S 2005-2006 OUTBREAKS OCCUR?

¶8. (U) In India, the first documented recent report of chikungunya came in December 2005, in Andhra Pradesh. By mid-April of 2006, the suspected cases numbered over 25,000 in Andhra Pradesh, over 36,000 in Karnataka, and over 65,000 in Maharashtra. Families reported multiple cases across all age groups. Eventually, chikungunya found its way to Kerala, where the press reported Kerala,s Chief Minister V.S. Achuthanandan as saying that deaths due to chikungunya had occurred in Kerala. In 2006, after the floods and heavy rains in the north, cases of chikungunya were reported all over Rajasthan, Gujarat, and Madhya Pradesh.

¶9. (U) The re-emergence of the virus is a cause for concern as it could become a major public health problem. Its re-emergence could be linked to a variety of social, environmental, behavioral, and biological changes. It may also indicate the existence of a low-level, asymptomatic, persistent infection in India which was not being documented. The current outbreak is different than previous ones, which predominantly affected urban areas. Now chikungunya outbreaks are found in both urban and rural areas. It is important to note that active surveillance for chikungunya has not occurred during lulls in major outbreaks and that the virus is spreading throughout India.

DEADLY VIRUS COULD KILL TOURISM

¶10. (U) In 2006, GOI pulled together a team of experts to probe the cause of reported chikungunya-related mortalities in Kerala. The team had officials from the NICD, NIV, World

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Health Organization (WHO), and the National Vector Borne Disease Control Program (NVBDCP). This team submitted a report to the Ministry of Health (MOH) which ruled out chikungunya as a cause for death. NVBDCP Chief P.L. Joshi said &There is no death due to chikungunya in the country and the deaths in Kerala and other places are due to other related diseases such as TB, cancer and cardiac problems.8 WHO,s India Representative, Salim Habayeb, and GOI Health Minister Anbumani Ramadoss both corroborated this statement.

¶11. (SBU) ICMR,s NIV director, however, shared the results of its epidemiological, clinical, and laboratory investigations of the chikungunya outbreak with a visiting Centers for Disease Control and Prevention (CDC) delegation. These results showed at least a ten fold increase in the

number of chikungunya cases over what the GOI reported and a correlation of death with infection. Although the State Governments of Andhra Pradesh, Karnataka, and Maharashtra declared deaths and high numbers of infections, a senior MOH official told Health Attach, "Kerala is our tourism destination, and it would be a disaster if this state was labeled as a place of infection." For its own political and economic reasons, it seems the GOI is playing down the rate of infection and deaths associated with the virus.

HUNT FOR CHIKUNGUNYA VACCINE ON

¶12. (U) In the late 1970s, US Army scientists at the Walter Reed Army Institute of Research and the US Army Medical Research Institute of Infectious Disease (USAMRIID) developed the only known chikungunya vaccine tested on humans from a live attenuated vaccine developed from a patient in Thailand.

The research stopped in 1997 due to difficulties with funding and a difficulty envisioning how final field efficacy trials would be conducted due to the unpredictable nature of chikungunya outbreaks.⁸ In September 2006, US Embassy Paris announced a USG agreement to transfer research records, vaccine supplies and seed stocks to the French, so they could resume vaccine development. Scientists in France have started laboratory safety testing of a chikungunya vaccine. According to press reports, French scientists plan to start clinical trials in September 2007.

¶13. (SBU) Hyderabad based Bharat Biotech India Ltd (BBIL), a premier Indian biotech industry innovator, also has development of a chikungunya vaccine in the pipeline. Though BBIL met with a French delegation regarding a potential

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partnership at the end of 2006, nothing was agreed to. In the end they realized they are working on different methodologies for developing a vaccine.

COMMENT: A GLOBAL PROBLEM AND POTENTIAL BIOTERRORISM AGENT

14.(SBU) The CDC already lists chikungunya (viral encephalitis and alphaviruses) as a Category B Biological Weapons Agent. Category B is the second highest priority for defense because it is composed of agents that are easy to disseminate, cause moderate morbidity, low mortality, and would require enhancements of the US surveillance and diagnostic capacity if there were an outbreak. In India, the lack of disease surveillance and transparency in reporting infections, insufficient testing laboratories, and the dichotomy of statements between scientists, state authorities and the policy makers in Delhi make India's national health structure particularly vulnerable.

¶15. (U) Mission will continue watching and reporting on chikungunya and other emerging and reemerging infectious diseases. HHS/CDC is engaged with the MOH on emerging and re-emerging infectious diseases under the auspices of an Indo-US bilateral agreement on Emerging and Reemerging Infectious Diseases and Disease Surveillance (ERIDDS). This interaction provides HHS staff at the Mission access to unpublished data on disease surveillance and disease burden.
End Comment.
MULFORD